

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395379	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025
NAME OF PROVIDER OR SUPPLIER Wecare at Sycamore Rehabilitation and Nursing Cent		STREET ADDRESS, CITY, STATE, ZIP CODE 1445 Sycamore Road Montoursville, PA 17754	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29512</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to honor advance directive choices for one of 22 residents reviewed (Resident 53).</p> <p>Findings include:</p> <p>Clinical record review for Resident 53 revealed that on [DATE], their physician ordered staff to Do Not Resuscitate (DNR), which continued throughout the resident's facility stay until February 20, 2025, after identified by the surveyor.</p> <p>There was documentation on February 7, 2025, at 1:35 PM that indicated the facility contacted Resident 53's responsible party to complete a POLST (Pennsylvania Orders for Life-Sustaining Treatment, a form directing medical staff to complete life-sustaining treatment or allow a natural death) form. On February 11, 2025, Resident 53's responsible party completed the POLST and indicated that staff should complete CPR (cardiopulmonary resuscitation) should the need arise. On February 11, 2025, at 8:10 AM staff acknowledged that Resident 53's responsible party completed a POLST form the day prior.</p> <p>There was no documentation that the facility identified that Resident 53's responsible party wished for them to have CPR and discontinued Resident 53's DNR order until identified by the surveyor.</p> <p>The surveyor reviewed the above information during an interview on February 20, 2025, at 2:30 PM with the Director of Nursing and the Nursing Home Administrator.</p> <p>28 Pa. Code 201.29(d) Resident rights</p> <p>28 Pa. Code 211.10(a) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>20725</p> <p>Based on clinical record review and staff interview it was determined that the facility failed to provide required notification to a resident whose payment coverage changed for three of three residents reviewed (Residents 72, 101, and CR119).</p> <p>Findings include:</p> <p>A review of the form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123, (a notice that informs the recipient when care received from the skilled nursing facility is ending; and how to contact a Quality Improvement Organization (QIO) to appeal) revealed instructions that a Medicare provider must ensure that the notice is delivered at least two calendar days before Medicare covered services end. The provider must ensure that the beneficiary or their representative signs and dates the NOMNC to demonstrate that the beneficiary or their representative received the notice and understands the termination of services can be disputed. If the provider is personally unable to deliver a NOMNC to a person acting on behalf of an enrollee, then the provider should telephone the representative to advise him or her when the enrollee's services are no longer covered. Confirm the telephone contact by written notice mailed on that same date.</p> <p>A review of the Form Instructions Skilled Nursing Facility (SNF) Advanced Beneficiary Notice of Non-coverage (SNFABN) Form CMS-10055 revealed that examples of the common reasons why an extended care stay, or services may not be covered under Medicare might include the beneficiary no longer requires daily skilled care for a medical condition but wants to continue residing in the skilled nursing facility (SNF). The SNF enters a good faith estimate of the cost of the corresponding care that may not be covered by Medicare. In the blank that follows Beginning on ., the skilled nursing facility enters the date on which the beneficiary may be responsible for paying for care that Medicare is not expected to cover. The beneficiary selects an option box to indicate a desire to continue to receive the care or not to continue to receive the care and if there is a desire to have the bill submitted to Medicare for consideration. The beneficiary or their authorized representative must sign the signature box to acknowledge that they read and understood the notice.</p> <p>The SNF must issue this notice when there is a termination of all Medicare Part A services for coverage reasons. If after issuing the NOMNC, the SNF expects the beneficiary to remain in the facility in a non-covered stay, the SNFABN must be issued to inform the beneficiary of potential liability for the non-covered stay.</p> <p>Clinical record review of census information for Resident 72 revealed that the facility provided services primarily paid for by Medicare starting August 14, 2024. Resident 72's Medicare payment for services ended November 21, 2024. Resident 72 remained in the facility.</p> <p>The surveyor reviewed concerns that the facility did not provide a CMS10123 or CMS10055 notice provided to Resident 72 upon the change in the payment source for her care during an interview with the Nursing Home Administrator and the Director of Nursing on February 19, 2025, at 2:30 PM.</p> <p>(continued on next page)</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Nursing Home Administrator on February 20, 2025, at 9:30 AM confirmed that the facility had no further evidence that Resident 72 received appropriate notices of changes in the payment coverage for services received.</p> <p>Clinical record review of census information for Resident 101 revealed that the facility provided services primarily paid for by Medicare starting December 9, 2024. Resident 101's Medicare payment for services ended January 1, 2025. Resident 101 remained in the facility.</p> <p>Review of a CMS10055 notice provided by the facility for Resident 101 revealed that Resident 101's representative signed the notice on December 30, 2024; however, the representative did not select an option box to indicate that there was a desire to continue to receive the care, or not to continue to receive the care, or if there was a desire to have the bill submitted to Medicare for consideration.</p> <p>Interview with the Nursing Home Administrator on February 19, 2025, at 2:30 PM confirmed the above findings for Resident 101.</p> <p>Closed clinical record review of census information for Resident 119 revealed that the facility provided services primarily paid for by Medicare starting November 14, 2024. Resident 119's Medicare payment for services ended December 11, 2024. The facility discharged Resident 119 on December 12, 2024.</p> <p>Review of a CMS10123 notice provided by the facility for Resident 119 revealed that Resident 119 signed the notice on December 10, 2024. A handwritten notation on the notice indicated that staff provided verbal notice on December 9, 2024.</p> <p>Nursing documentation created December 10, 2024, at 11:06 AM indicated that the CMS10123 notice was issued verbally on December 9, 2024. There was no indication that a circumstance prevented staff from delivering the required written (rather than verbal) notice at least two calendar days before Medicare covered services ended.</p> <p>Interview with the Nursing Home Administrator on February 19, 2025, at 2:30 PM confirmed that Resident 119 resided in the facility until her discharge on December 12, 2024; therefore, there was no circumstance that prevented the provider from personally providing the written notice to Resident 119 timely.</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa. Code 201.29(a) Resident rights</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>18229</p> <p>Based on review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to report an allegation of misappropriation of resident property for one of three closed records reviewed (Resident 118, Employee 2).</p> <p>Findings include:</p> <p>The facility policy entitled Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, last reviewed without changes January 23, 2025, revealed all reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator, and to other officials according to state law. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies:</p> <ul style="list-style-type: none"> a. the state licensing/certification agency responsible to surveying/licensing the facility b. the local/state ombudsman c. the resident's representative d. adult protective services e. law enforcement officials f. the resident's attending physician g. the facility medical director <p>Immediately is defined as within two hours of an allegation involving abuse or result in serious bodily injury, or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.</p> <p>Department of Health received a complaint on January 24, 2025, indicating Employee 2 (registered nurse) stole Resident 118's narcotics and noted the allegation was reported to the facility Director of Nursing and Employee 1 (corporate consultant) by two nurses.</p> <p>Review of Resident 118's closed clinical record revealed no documentation of the allegation of misappropriation of her narcotics.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Director of Nursing and Employee 1 on February 21, 2025, at 1:48 PM confirmed the facility was made aware of the allegation related to the misappropriation of Resident 118's narcotics. Employee 1 provided documentation of the two emails the Director of Nursing received alleging the misappropriation of Resident 118's narcotics by Employee 2. The Director of Nursing received the first email from Employee 6 (registered nurse) on January 21, 2025, at 8:11 AM. The Director of Nursing received the second email from Employee 7 (licensed practical nurse) on January 21, 2025, at 8:32 AM. The Director of Nursing and Employee 1 confirmed they did not notify the agencies listed above of the allegation.</p> <p>The facility failed to report an allegation of misappropriation of resident property to the appropriate agencies.</p> <p>28 Pa. Code 201.14(a)(c) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(1)(2)(e)(1)Management.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20725</p> <p>Based on clinical record review and staff and resident interview it was determined that the facility failed to ensure assessments accurately reflected a resident's status for one of 22 residents reviewed (Resident 113).</p> <p>Findings include:</p> <p>Clinical record review for Resident 113 revealed an admission MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) assessment dated [DATE], that indicated he received five insulin (injectable hormone medication used to lower blood sugar) injections during the previous seven days (or since his admission to the facility).</p> <p>Interview with Resident 113 on February 19, 2025, at 10:21 AM revealed that he had never received an insulin injection, and that he does not have a diabetes diagnosis (medical condition that results in elevated blood sugar).</p> <p>Interview with the Nursing Home Administrator on February 21, 2025, at 9:33 AM confirmed that the MDS assessment that indicated Resident 113 received insulin injections was completed in error.</p> <p>28 Pa. Code 211.5(f) Medical records</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18229</p> <p>Based on clinical record review, observation, and staff and resident interview, it was determined that the facility failed to provide bathing assistance for residents dependent on staff assistance for 5 of 6 residents sampled for activities of daily living (Residents 22, 92, 7, 43, and 70).</p> <p>Findings include:</p> <p>Observation of Resident 22 on February 18, 2025, at 10:32 AM and February 19, 2025, at 10:40 AM revealed she was in bed and her hair appeared disheveled. Attempts to interview Resident 22 at these times related to her showers were unsuccessful. Resident 22 stated she was unable to remember when she last had a bath or shower.</p> <p>Clinical record review revealed the facility admitted Resident 22 on September 25, 2023. A review of Resident 22's most recent MDS (Minimum Data Set, an assessment completed at specific intervals to determine care needs) dated January 23, 2025, indicated nursing staff assessed Resident 22 as dependent on staff for bathing.</p> <p>A review of Resident 22's task documentation (ADL, activities of daily living charting) for the last 30 days revealed Resident 22 only received one shower, and seven bed baths. There was no documentation of Resident 22 refusing a shower/bath.</p> <p>Further review of Resident 22's clinical record revealed that Resident 22's bathing preference was identified as showers twice a week.</p> <p>Clinical record review revealed the facility admitted Resident 92 on January 5, 2024. A review of Resident 92's MDS dated [DATE], indicated nursing staff assessed Resident 92 as dependent on staff for bathing.</p> <p>A review of Resident 92's task documentation for the last 30 days revealed Resident 92 only received one shower, and seven bed baths. There was no documentation of Resident 92 refusing a shower/bath. Further review of Resident 92's clinical record revealed that Resident 92's bathing preference was identified as showers twice a week.</p> <p>Clinical record review revealed the facility admitted Resident 7 on December 2, 2015. A review of Resident 7's most recent MDS dated [DATE], indicated nursing staff assessed Resident 7 as requiring substantial/maximum assistance. Review of Resident 7's bathing preference revealed Resident 7 prefers showers on the first shift.</p> <p>A review of Resident 7's task documentation revealed staff documented NA (not applicable) on February 19, 2025, for Resident 7's shower. The surveyor observed Resident 7 in her wheelchair at the nurse's station on February 19, 2025, at 8:47 AM, 9:23 AM, 10:57 AM, 12:41 PM, 1:17 PM, and 3:32 PM.</p> <p>Resident 7 was unable to be interviewed due to her current cognitive status. There was no documentation of Resident 7 refusing, or staff attempting to bath Resident 7 on February 19, 2025.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Findings for Residents 22, 7, and 92 were reviewed with the Nursing Home Administrator and Director of Nursing on February 19, 2025, at 2:37 PM</p> <p>Clinical record review for Resident 43 revealed that the facility completed an annual MDS assessment on December 21, 2024, that indicated they were not cognitively intact. Staff completed the assessment of daily and activity preferences and noted that Resident 43 was receiving a shower and not receiving a sponge bath. The MDS also identified that they were dependent on staff to shower and/or bathe self.</p> <p>Review of Resident 43's task documentation (documentation where staff indicate completion of ADL care) revealed that since July 31, 2024, staff was to complete ADL - Bathing (prefers showers) on Monday and Thursday day shift.</p> <p>Review of Resident 43's task documentation revealed that staff did not complete the ADL-Bathing per the resident's preference. There was documentation that indicated staff provided bed baths to Resident 43 instead of showers:</p> <p>January 2, 6, 9, 13, 16, 20, 23, 27, and 30, 2025</p> <p>February 3, 6, 10, 13, and 17, 2025</p> <p>Resident 43 was observed on February 18, 2025, at 12:35 PM in his bed. His hair was disheveled. Resident 43 was cognitively impaired an unable to be interviewed.</p> <p>Clinical record review for Resident 70 revealed that the facility completed an initial MDS assessment on July 17, 2024, that indicated it was very important that they choose between a tub bath, shower, bed bath, or sponge bath. The facility completed a quarterly MDS on November 12, 2024, that identified Resident 70 was dependent on staff to shower and/or bathe self.</p> <p>Review of Resident 70's task documentation revealed that between October 30, 2024, and December 12, 2024, staff was to complete ADL-Showers on Tuesday and Friday second shift and between December 12, 2024, and January 16, 2025, staff was to complete ADL -Showers on Tuesday and Friday third shift. On January 16, 2025, the facility switched Resident 70's showers back to Tuesday and Friday second shift.</p> <p>Review of Resident 70's task documentation revealed that staff did not complete the ADL-Showers per the resident's preference. There was documentation that staff provided a bed bath to Resident 70 instead of a shower on the following dates:</p> <p>December 20, 2024</p> <p>January 17 and 24, 2025</p> <p>February 7 and 14, 2025</p> <p>Further review of Resident 70's task documentation revealed that staff documented RR (resident refused), documented NA, or did not document that showers were completed on the following dates:</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>December 3, 6, 10, 13, 24, 27, and 31, 2024</p> <p>January 3, 7, 10, 14, 29, and 31, 2025</p> <p>February 4, 2025</p> <p>There was no documentation that indicated staff re-approached and/or re-addressed bathing or provided Resident 70 the opportunity to shower the next shift or following day.</p> <p>Resident 70 was observed on February 18, 2025, at 12:33 PM and February 20, 2025, at 8:30 AM in the hallway by the nurse's station. Resident 70 was cognitively impaired an unable to be interviewed.</p> <p>The above information was reviewed during an interview with the Nursing Home Administrator and the Director of Nursing on February 20, 2025, at 2:35 PM.</p> <p>The facility failed to provide bathing assistance for a resident dependent on staff assistance.</p> <p>28 Pa Code 211.11(d)(1)(5) Nursing services</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>18229</p> <p>Provide activities to meet all resident's needs.</p> <p>Based on clinical record review, facility documentation, and staff interview, it was determined that the facility failed to provide an ongoing program of activities designed to meet the individual needs and interests for one of one resident reviewed for activities (Resident 7).</p> <p>Findings include:</p> <p>Review of Resident 7's current care plan revealed Resident 7 was dependent on staff for meeting emotional, intellectual, physical, and social needs. Interventions included to invite Resident 7 to scheduled activities of possible interest including mass, musical programs, holiday or celebratory events, live entertainment, pet visits, and craft activities. Resident 7's care plan noted she needs assistance, or escort to activity functions, may need some reassurance and assistance with communication during activities, and she enjoys playing with her busy blanket.</p> <p>Observation of Resident 7 on February 18, 2025, at 9:53 AM, 1:38 PM, and 3:27 PM revealed Resident 7 was in a wheelchair sitting at the nurses' station. Resident 7 did not have her busy blanket.</p> <p>Observation of Resident 7 on February 19, 2025, at 9:24 AM, 10:49 AM, 1:02 PM, and 3:37 PM revealed Resident 7 was in a wheelchair sitting at the nurses' station. Resident 7 did not have her busy blanket.</p> <p>Observation of Resident 7 on February 20, 2025, at 11:13 AM, 1:14 PM, 2:37 PM, and 3:41 PM revealed Resident 7 was in a wheelchair sitting at the nurses' station. Resident 7 did not have her busy blanket.</p> <p>Review of Resident 7's activity log for January 2025, revealed she attended an activity on January 2 and 31, 2025. There was no documentation of Resident 7 refusing any activities.</p> <p>Review of Resident 7's activity log for February 2025, revealed she attended an activity on February 13, 2025. There was no documentation of Resident 7 refusing any activities.</p> <p>Interview with Employee 3 (activity director) on February 21, 2025, at 9:02 AM revealed she has two activity aides, one activity aide works on the dementia unit and the other activity aide works with the rest of the residents (87 residents). Employee 3 confirmed the above findings for Resident 7 that staff have only taken her to three activities in the last two months.</p> <p>The findings were reviewed with the Administrator on February 21, 2025, at 10:05 AM.</p> <p>The facility failed to provide an ongoing program of activities to meet the needs of Resident 7.</p> <p>28 Pa. Code 201.29 (a) Resident rights</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>29512</p> <p>Based on clinical record review, observation and resident and staff interview, it was determined that the facility failed to provide the highest practicable care regarding physician orders, medications, and treatments for six of 22 residents reviewed (Residents 22, 33, 42, 70, 109, 112, and 114).</p> <p>Findings include:</p> <p>Clinical record review for Resident 42 revealed physician orders for staff to administer the following:</p> <p>Atorvastatin Calcium 20 milligrams (mg) at bedtime for hyperlipidemia (high fat in bloodstream)</p> <p>Senna 2 tablets at bedtime for constipation</p> <p>Tums 500 mg 2 tablets at bedtime for GERD (reflux)</p> <p>Acetaminophen Extended Release 650 mg BID (twice daily) for mild pain 1-3</p> <p>Famotidine 20 mg every 12 hours for stomach ulcers</p> <p>Tramadol 50 mg one-half tablet BID for pain</p> <p>Review of Resident 42's January 2025, MAR (medication administration record, a form to document medication administration) revealed that there was no documentation that staff administered their medications on January 28, 2025, during the evening shift.</p> <p>Clinical record review for Resident 70 revealed physician orders for staff to administer the following:</p> <p>Carbidopa-Levodopa Extended Release 50-200 mg one-half tablet BID for Parkinson's disease</p> <p>Lamotrigine 25 mg three tablets BID for seizures</p> <p>Memantine Hydrochloride (HCl) 5 mg BID for dementia</p> <p>Gabapentin 100 mg 1 capsule three times daily (TID) for Neuropathy</p> <p>Tylenol 325 mg three tablets TID for pain</p> <p>Carbidopa-Levidopa 25-100 mg one tablet four times daily (QID) for Parkinson's disease</p> <p>Potassium Chloride 20 milliequivalents daily at 4:00 PM for hypokalemia (low potassium)</p> <p>Midodrine HCl 5 mg TID for hypotension (low blood pressure) hold for systolic blood pressure (SBP, number when the heart is beating) greater than 140 mmHg (millimeters mercury)</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Wecare at Sycamore Rehabilitation and Nursing Cent		STREET ADDRESS, CITY, STATE, ZIP CODE 1445 Sycamore Road Montoursville, PA 17754	
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ascorbic Acid 250 mg one table daily for deficiency</p> <p>B-Complex one tablet daily for supplement</p> <p>Cyanocobalamin 1000 micrograms (mcg) one table daily for supplement</p> <p>Docusate Sodium 100 mg two capsules daily for constipation</p> <p>Fludrocortisone Acetate 0.1 mg two tablets by mouth daily for hypotension</p> <p>Memantine HCl 5 mg in the morning for dementia</p> <p>Potassium Chloride 20 mEq (milliequivalents), give 40 mEq daily at 8:00 AM for hypokalemia</p> <p>Senna 8.6 mg 2 tablets at bedtime for constipation</p> <p>Tamsulosin HCl 0.4 mg one capsule daily for benign prostate hyperplasia</p> <p>Review of Resident 70's January and February 2025, MAR revealed that there was no documentation that staff administered their medications on January 28, 2025, during the evening shift and on February 15, 2025, during the day shift.</p> <p>Further review of Resident 70's January and February 2025, MAR revealed that staff administered their Midodrine medication when the SBP reading was greater than 140, noted N/A, or did not administer the medication on the following dates:</p> <p>January 1, 2025, at 4:00 PM 143/77 mmHg</p> <p>January 2, 2025, at 4:00 PM 148/86 mmHg</p> <p>January 11, 2025, at 8:00 AM 157/77 mmHg</p> <p>January 11, 2025, at 4:00 PM 152/80 mmHg</p> <p>January 15, 2025, at 8:00 AM 144/77 mmHg</p> <p>January 17, 2025, at 8:00 AM 143/66 mmHg</p> <p>January 19, 2025, at 4:00 PM, 142/72 mmHg</p> <p>February 3, 2025, at 12:00 PM 150/77 mmHg</p> <p>February 6, 2025, at 8:00 AM 144/65 mmHg</p> <p>February 9, 2025, at 4:00 PM N/A</p> <p>February 14, 2025, at 12:00 PM 144/78 mmHg</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>February 15, 2025, at 8:00 AM and 12:00 PM, no documentation of blood pressure or medication administration</p> <p>The surveyor reviewed the above information during an interview on February 20, 2025, at 2:38 PM with the Nursing Home Administrator and Director of Nursing.</p> <p>Clinical record review for Resident 33 revealed a current physician's order for staff to administer her Oxycodone (a medication used to treat moderate to severe pain) 10 mg every six hours, and to hold if resident is lethargic (a lack of mental alertness) or has a respiratory rate (the number of breaths a person takes in a minute) below 10.</p> <p>Further review of Resident 33's clinical record documentation for February 1-18, 2025, revealed that there was no documentation to indicate that staff monitored her respiratory rate prior to administering the medication Oxycodone to her for February 6-17, 2025.</p> <p>Employee 1, corporate regional director, confirmed the above noted findings related to Resident 33 on February 21, 2025, at 1:26 PM.</p> <p>Observation of Resident 109 on February 18, 2025, at 2:22 PM revealed swelling (edema) of her bilateral lower legs, ankles, and feet. The edema was greater in her right leg when compared to her left leg. Interview with Resident 109 on the date and time of the observation revealed that she wore a beige stocking on her right leg that she believed was for compression of the edema. Resident 109 stated that she was diagnosed with an infection in her right knee joint that made the edema in her right leg worse.</p> <p>Nursing documentation dated February 18, 2025, at 3:52 PM revealed that Resident 109's primary physician assessed her on this date. The nursing documentation indicated that the nursing staff assessed Resident 109's legs to determine that her, .Legs seem less swollen.</p> <p>Clinical record review for Resident 109 revealed no physician order for staff to apply a compression garment on Resident 109's legs. Review of plans of care developed by the facility to address Resident 109's care needs revealed no plan of care intervention related to compression stockings to her legs.</p> <p>The surveyor reviewed the above concern regarding Resident 109's use of a compression stocking on her right leg during an interview with the Director of Nursing and the Nursing Home Administrator on February 20, 2025, at 2:30 PM.</p> <p>A physician's order obtained by the Director of Nursing on February 20, 2025, at 6:39 PM (following the surveyor's questioning) instructed staff that Resident 109 could wear tubi-grip stockings (soft elastic support bandage that may be used for strains, sprains, swelling, leg ulcers, etc.) to her right lower leg as needed for edema and comfort.</p> <p>Facility staff revised the plan of care created to address Resident 109's skin integrity impairment of her sacrum (tailbone) and right knee on February 20, 2025, to include the intervention that Resident 109 may wear the tubi-grip to her right lower leg as needed for comfort.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with Resident 112 on February 18, 2025, at 1:34 PM revealed that he had an internal cardiac pacemaker (medical device implanted in the chest to use electrical impulses to treat abnormal heart rhythms), and he had a machine at home that monitored his heart rate and pacemaker function.</p> <p>Clinical record review for Resident 112 revealed that the facility admitted him on January 23, 2025.</p> <p>A hospital After Hospital Care Plan, dated January 23, 2025, at 9:16 AM revealed that the hospital admitted Resident 112 on January 9, 2025, due to chest pain.</p> <p>Documentation by the hospital cardiology provider (doctor who specializes in caring for those with heart conditions) dated January 10, 2025, indicated that Resident 112 had .bradycardia (slow heart rate), and permanent pacemaker .</p> <p>Resident 112's clinical record contained no active physician order or plan of care intervention that indicated Resident 112 had an implanted cardiac pacemaker.</p> <p>The surveyor reviewed the above concerns regarding Resident 112's implanted cardiac pacemaker during an interview with the Director of Nursing, the Nursing Home Administrator, and Employee 1 on February 19, 2025, at 2:30 PM.</p> <p>Nursing documentation dated February 20, 2025, at 2:55 PM (following the surveyor's questioning) revealed that Resident 112's wife brought a pacemaker monitoring machine to the facility.</p> <p>Physician orders obtained by facility staff on February 20, 2025, at 3:00 PM (following the surveyor's questioning), instructed staff to check the cardiac monitor to ensure that the remote monitor is plugged in. If the monitor has a test button, press to ensure it is working properly. If the monitor has a light for in use, ensure that the light is on. The orders included a telephone number that staff are to call with any issues regarding the pacemaker monitoring. Resident 112 was to have a pacemaker check on February 25, 2025, at 1:00 PM and every six months.</p> <p>The facility updated Resident 112's diagnoses list on February 20, 2025, to include the presence of a cardiac pacemaker.</p> <p>Clinical record review for Resident 114 revealed an active physician's order dated January 30, 2025, for staff to assess a PICC (peripherally inserted central catheter, a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near the heart) line site every shift for redness, infiltration, and/or swelling.</p> <p>An active physician's order dated January 31, 2025, instructed staff to change a PICC line dressing weekly using a sterile technique.</p> <p>Review of Resident 114's TAR dated February 2025, revealed that nursing staff initialed completion of the PICC line dressing change daily (not weekly as per the physician's order) every 14 days from February 1 to 20, 2025. Licensed practical nursing (LPN) staff documented completion of the PICC line dressing change on each of the 14 days.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A physician's order active since January 31, 2025, instructed staff to administer 750 mg (milligrams) of Vancomycin HCl (antibiotic medication administered intravenously for complicated infections) intravenously two times a day for empyema (an infection in which pus develops in the hollow space between the lungs and underneath the chest wall).</p> <p>A physician's order dated January 31, 2025, instructed staff to flush Resident 114's PICC line with normal sterile saline two times a day after the administration of the intravenous medication.</p> <p>Review of Resident 114's MAR dated February 2025, revealed that staff failed to document the administration of the Vancomycin medication on the first shift on February 9 and 13, 2025. Staff failed to document the administration of the Vancomycin medication on second shift on February 11 and 13, 2025. The documentation indicated that LPN staff initialed the intravenous administration of the Vancomycin medication on 16 of the 37 possible administrations from February 1 through 19, 2025.</p> <p>Review of Resident 114's MAR dated February 2025 revealed that staff failed to document the saline flushes on first shift February 9, and 13, 2025; and second shift on February 11, 13, and 17, 2025. The documentation indicated that LPN staff initialed the completion of the saline flushes on 18 of the possible 38 administrations from February 1 through 19, 2025 (missing 21 administrations).</p> <p>Interview with the Nursing Home Administrator on February 19, 2025, at 2:30 PM revealed that LPN staff provided written witness statements that they did not complete the treatments via Resident 114's PICC line, but they initialed completion of care completed by the registered nurses. The interview confirmed that it is the facility's policy that only the staff who administer medications or complete treatments initial for the completion of the care. The interview confirmed that the facility does not have LPN staff who are certified to perform intravenous therapy via a PICC line. The facility did not know every registered nurse that permitted the LPN to initial care that they did not perform.</p> <p>Plans of care initiated by the facility on January 31, 2025, stipulated that Resident 114 required the use of a central access device (central venous catheter (CVC), tubing inserted into a large central vein, most commonly the internal jugular or subclavian). The plans of care did not indicate emergency procedures staff were to use in the event of an emergency (e.g., apply pressure, clamp tubing, etc.). The plans of care did not indicate a need for an emergency kit at Resident 114's bedside to address potential emergent complications from the PICC access site. The plans of care did not include an intervention to not use his right arm for blood draws or blood pressure assessments.</p> <p>Interview with Resident 114 on February 19, 2025, at 9:30 AM confirmed that he received intravenous antibiotics via tubing in his right arm. The surveyor was unable to view the site as Resident 114's sweatshirt sleeve covered the area. Resident 114 stated that he was unaware of any equipment in his room that would be available in the event of a complication from his intravenous access site (e.g., pressure dressings or clamp). Observation of Resident 114 and his room during the interview revealed no indicators that Resident 114 had right arm use restrictions (e.g., a sign to warn a contracted phlebotomist to not use the right arm to obtain blood).</p> <p>A physician's order dated January 31, 2025, instructed staff to report laboratory results weekly (on Fridays).</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with Employee 4 (licensed practical nurse) on February 18, 2025, at 1:54 PM confirmed that there was no signage or emergency kit materials in Resident 114's room related to his PICC. Employee 4 stated that she believed the facility had a protocol that required the use of signs to prevent staff from using an affected limb and the placement of an emergency kit.</p> <p>Observation of Resident 114's room on February 20, 2025, at 10:52 AM (following the surveyor's questioning) revealed a sign above his bed to not use his right arm for blood pressures or blood draws.</p> <p>The surveyor reviewed the above concerns regarding Resident 114's PICC line emergency procedures and planned care during an interview with the Nursing Home Administrator, the Director of Nursing, and Employee 1 on February 19, 2025, at 2:30 PM.</p> <p>Clinical record review revealed the facility admitted Resident 22 on September 25, 2023. Nursing documentation dated January 13, 2025, at 3:29 PM noted Resident 22 stated she was having chest pain. Vital signs noted her pulse was tachycardic (heart beats too fast) at 123 bpm (beats per minute). Further review of the nursing documentation indicated nitro as ordered- first nitro given pulse 112, second nitro given pulse 108, third nitro given pulse 104. The physician's assistant and physician were called to Resident 22's room and ordered Oxycodone as the physician felt it was probably sternum pain. The physician ordered vital signs every two hours times three.</p> <p>Review of Resident 22's vital sign documentation revealed that nursing staff did not complete any of the physician ordered vital signs.</p> <p>Nursing documentation dated January 14, 2025, at 12:25 PM revealed that Resident 22 again complained of chest pain. The nurse noted that Resident 22's vital signs were obtained and within normal limits. Review of Resident 22's vital sign documentation on January 14, 2025, at 11:03 AM revealed Resident 22's pulse was 126 bpm (beats per minute, normal heart rate for the elderly is 60 to 100 bpm).</p> <p>Interview with the Nursing Home Administrator and Director of Nursing on February 21, 2025, at 10:37 AM confirmed these findings for Resident 22.</p> <p>483.25 Quality of Care</p> <p>Previously cited 3/15/24</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18229</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to provide services to maintain a resident's range of motion for one of four residents reviewed for ROM concerns (Resident 7).</p> <p>Findings include:</p> <p>Clinical record review revealed the facility admitted Resident 7 on December 2, 2015. Review of Resident 7's most recent quarterly MDS (Minimum Data Set, an assessment completed at specific intervals to determine care needs) dated November 22, 2024, noted staff assessed Resident 7 as having no upper or lower extremity impairments.</p> <p>Further review of Resident 7's clinical record revealed her next MDS assessment dated [DATE], nursing staff assessed Resident 7 as having a limited range of motion (ROM, movement of the body to maintain a resident's ability) bilaterally to her upper and lower extremities.</p> <p>Review of Resident 7's clinical record revealed she was discharged from physical therapy on December 26, 2024, and occupational therapy on November 15, 2024.</p> <p>The facility was unable to provide any further documentation that the facility assessed Resident 7's decline in her range of motion. The facility failed to ensure Resident 7 received appropriate treatment and services to increase range of motion or prevent further decrease in her range of motion.</p> <p>Interview with the Nursing Home Administrator on February 20, 2025, at 9:58 AM confirmed these findings.</p> <p>483.25(c)(2) Mobility</p> <p>Previously cited 3/15/24</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18229</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to assess and implement individualized interventions to promote bowel and bladder continence for one of one resident reviewed for incontinence (Resident 55).</p> <p>Findings include:</p> <p>Clinical record review revealed the facility admitted Resident 55 on January 20, 2025. Review of Resident 55's admission MDS (Minimum Data Set, an assessment completed at specific intervals to determine care needs) assessment dated [DATE], revealed that staff assessed Resident 55 as frequently incontinent of his bowel and bladder, with no attempts at a toileting program. Staff also assessed Resident 55 as dependent on staff for toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement).</p> <p>Review of Resident 55's care plan initiated on January 21, 2025, revealed that Resident 55 has an activities of daily living self-care performance deficit related to his impaired balance and required extensive assistance of one staff for his toileting needs.</p> <p>Further review of Resident 55's clinical record revealed no assessment or treatment interventions to address Resident 55's bowel and bladder incontinence.</p> <p>Interview with the Nursing Home Administrator and Director of Nursing during a meeting on February 20, 2025, at 2:37 PM confirmed there was no evidence that the facility further assessed Resident 55 to implement interventions to promote bowel and bladder continence.</p> <p>The facility failed to appropriately identify, assess, and provide appropriate treatment and services to achieve or maintain as much bowel and bladder function as possible.</p> <p>28 Pa. Code 21.12(d)(1)(5) Nursing services</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>18229</p> <p>Based on observation, clinical record review, and staff interview, it was determined that the facility failed to provide appropriate respiratory care and services for three of three residents reviewed (Residents 22, 6, and 70).</p> <p>Findings include:</p> <p>Observation of Resident 22 on February 18, 2025, at 10:32 AM and 2:02 PM revealed Resident 22 was in bed with a nasal cannula (NC, tubing to deliver oxygen to the nose) on and running at 4 liters per minute (LPM).</p> <p>Observation of Resident 22 on February 19, 2025, at 8:17 AM and 12:57 PM revealed Resident 22 was in bed with oxygen on and running at 4 LPM.</p> <p>Observation of Resident 22 on February 20, 2025, at 12:20 PM revealed Resident 22 was in bed with oxygen on and running at 4 LPM.</p> <p>Review of Resident 22's clinical record revealed there was no physician's order for Resident 22 to receive oxygen.</p> <p>Review of Resident 22's care plan-initiated November 23, 2023, noted Resident 22 had a risk for ineffective breathing patterns related to the use of oxygen.</p> <p>The Nursing Home Administrator and Director of Nursing confirmed these finding during a meeting on February 20, 2025, at 2:30 PM.</p> <p>According to the American Association for Respiratory Care proper cleansing of respiratory (nebulizer) equipment reduces infection risk. The longer a dirty nebulizer sits and is allowed to dry, the harder it is to clean thoroughly. Parts of the aerosol drug delivery device should be rinsed and then washed with soap and hot water after each treatment. Once completely dry, store the nebulizer cup and mouthpiece in a zip lock bag.</p> <p>Clinical record review for Resident 6 revealed a current physician's order for staff to provide oxygen at 2 LPM via NC (nasal canula, tubing to deliver oxygen to the nose) continuously every shift for supplementary oxygen and BiPAP (pressurized non-invasive air ventilation via mask) via full mask AirCurve ST 20/8, oxygen 2 LPM at bedtime for respiratory insufficiency, remove in the morning.</p> <p>Observation of Resident 6's oxygen concentrator on February 18, 2025, at 12:28 PM and February 20, 2025, at 8:48 AM revealed that their BiPAP mask was unbagged and hanging off the bedside stand. During the February 20, 2025, observation of Resident 6's oxygen concentrator revealed that it was running and set at 1.5 LPM and their NC was lying on the floor unbagged beside their bedside stand.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Clinical record review for Resident 70 revealed current orders for staff to apply a CPAP (pressurized non-invasive air ventilation via mask) using room air at hour of sleep (HS) and remove in the morning for obstructive sleep apnea. There were no physician orders for staff to administer oxygen to Resident 70.</p> <p>Observation of Resident 70's room on February 18, 2025, at 12:17 PM and February 20, 2025, at 8:32 AM revealed that there was an oxygen concentrator with an undated filled humidification cannister, and undated oxygen tubing attached to the concentrator. During the February 18, 2025, observation the oxygen concentrator was turned off and there was an unbagged and undated oxygen NC lying on the overbed table. A CPAP mask and tubing was lying on another table by the window. During the February 20, 2025, observation the oxygen concentrator was on, set to 4 LPM, and had oxygen tubing connected to a CPAP machine located on a bedside stand. CPAP tubing was lying under resident clothing on a chair near the window, and a NC was lying, unbagged and undated, on the floor by the oxygen concentrator.</p> <p>The above information was reviewed during an interview with the Director of Nursing and the Nursing Home Administrator on February 20, 2025, at 2:30 PM.</p> <p>483.25(i) Respiratory/tracheostomy Care and Suctioning</p> <p>Previously cited 3/15/24</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>29512</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to provide the highest practicable care regarding physician ordered pain medications for two of three residents reviewed (Residents 6 and 43)</p> <p>Findings include:</p> <p>Clinical record review for Resident 6 revealed physician orders for the following pain medications:</p> <p>Ordered on July 18, 2024, Acetaminophen (Tylenol, for mild pain) 325 milligrams (mg) 2 tablets by mouth (PO) every 6 hours as needed (PRN) for a pain scale of 1-3.</p> <p>Ordered on December 20, 2024, and discontinued on February 6, 2025, Oxycodone (for moderate to severe pain) 5 mg two tablets PO every 6 hours PRN for a pain scale of 8-10.</p> <p>Ordered on January 16, 2025, Oxycodone 5 mg one tablet PO every 6 hours PRN for a pain scale of 4-7.</p> <p>Ordered on January 16, 2025, and discontinued on February 6, 2025, Oxycodone 5 mg two tablets PO every 6 hours PRN for a pain scale of 8-10.</p> <p>Ordered on February 6, 2025, Oxycodone 10 mg one tablet PO every 6 hours PRN for a pain scale of 8-10.</p> <p>There was no documentation that the facility identified that Resident 6 had multiple Oxycodone orders for a pain scale of 8-10 between January 16, 2025, and February 6, 2025.</p> <p>Review of Resident 6's January and February 2025, MAR (medication administration record, a form to document medication administration) revealed the following:</p> <p>Staff administered the following PRN pain medicine:</p> <p>Oxycodone 5 mg two tablets PO every 6 hours PRN for a pain scale of 8-10</p> <p>January 1, 2025, at 9:01 PM for a pain level of 4</p> <p>January 6, 2025, at 4:00 PM for a pain level of 0</p> <p>January 28, 2025, at 10:29 PM for a pain level of 0</p> <p>January 31, 2025, at 9:13 PM for a pain level of 0</p> <p>February 4, 2025, at 4:02 PM for a pain level of 4</p> <p>Oxycodone 5 mg one tablet PO every 6 hours PRN for a pain scale of 4-7</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>February 10, 2025, at 9:19 PM for a pain level of 8</p> <p>February 11, 2025, at 4:14 AM for a pain level of 9</p> <p>February 12, 2025, at 9:29 PM for a pain level of 10</p> <p>Clinical record review for Resident 43 revealed physician orders for the following pain medications:</p> <p>Ordered on January 15, 2025, Oxycodone 5 mg one-half tablet PO every 6 hours PRN for a pain scale of 8-10.</p> <p>Review of Resident 43's February 2025, MAR revealed that staff administered their Oxycodone 5 mg PO one-half tablet every 6 hours PRN for a pain scale of 8-10 on February 12, 2025, at 9:33 PM for a pain level of 4.</p> <p>The above information was reviewed during an interview with the Nursing Home Administrator and Director of Nursing on February 20, 2025, at 2:49 PM.</p> <p>483.25(k) Pain Management</p> <p>Previously cited 3/15/24</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>20725</p> <p>Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to implement care to prevent potential complications from a dialysis access site for one of one resident reviewed for dialysis concerns (Resident 112).</p> <p>Findings include:</p> <p>Interview with Resident 112 on February 18, 2025, at 1:17 PM revealed that he required dialysis treatments (treatment for kidney failure; a machine filters extra fluid and waste products from the blood) three times a week; and that the treatment was administered through an access site (central venous catheter (CVC), tubing inserted into a large central vein, most commonly the internal jugular or subclavian) in his right upper chest. Resident 112 stated that he was unaware of any equipment in his room that would be available in the event of a complication from his dialysis access site (e.g., pressure dressings or clamp). Observation of Resident 112 and his room during the interview revealed no indicators that Resident 112 had right arm use restrictions (e.g., a sign to warn a contracted phlebotomist to not use the right arm to obtain blood).</p> <p>Clinical record review for Resident 112 revealed the following physician orders dated January 23, 2025:</p> <p>Do not take blood pressures on Resident 112's right arm.</p> <p>Monitor Resident 112's catheter site for pain, redness, swelling, or bleeding. If noted bleeding, apply a pressure dressing and notify the provider.</p> <p>Emergency kit for dialysis (to contain dressings and clamps) every Monday, Wednesday, and Friday for dialysis (this kit would go with Resident 112 when on leaves of absence from the facility for dialysis).</p> <p>A physician's order dated January 24, 2025, instructed that staff were not to provide Resident 112 a shower due to a dialysis IJ (internal jugular) catheter.</p> <p>There was no physician's order that restricted staff use of his right arm for blood draws or that required the placement of an emergency kit in Resident 112's room.</p> <p>Review of a plan of care developed by the facility to address Resident 112's need for dialysis revealed an intervention dated January 23, 2025, for staff to not draw blood or take blood pressure assessments in, .arm with graft (surgically created access site formed by using soft tubing to join a vein and an artery in an arm).</p> <p>Resident 112 did not have a dialysis graft in either arm.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Employee 4 (licensed practical nurse) on February 18, 2025, at 1:54 PM confirmed that there was no signage or emergency kit materials in Resident 112's room related to his CVC. Employee 4 stated that she believed the facility had a protocol that required the use of signs to prevent staff from using an affected limb and the placement of an emergency kit.</p> <p>A physician's order dated February 18, 2025, at 1:59 PM (following the surveyor's questioning) implemented the use of an emergency dialysis kit (clamps and four inch by four inch dressings). This physician's order was added to Resident 112's treatment administration record on February 18, 2025, and now required licensed staff to initial the implementation of the intervention every shift.</p> <p>The surveyor reviewed the above concerns regarding Resident 112's planned dialysis treatment and services related to his central line dialysis access site during an interview with the Nursing Home Administrator, Director of Nursing, and Employee 1 (corporate regional director) on February 19, 2025, at 2:30 PM.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29512</p> <p>Based on observation, clinical record review, and staff interview, it was determined that the facility failed to review the risk and benefits of side rail utilization with the resident or resident representative and receive consent for the use of side rails for four of five residents reviewed for accident hazards (Residents 33, 42, 70, and 109), and properly assess all zones that pose a risk for entrapment from bed rails on two of five residents reviewed (Residents 33 and 109).</p> <p>Findings include:</p> <p>Observation of Resident 42's room on February 18, 2025, at 12:14 PM and February 20, 2025, at 8:32 AM revealed that there were bilateral circular halo-type enabler bars on the bed.</p> <p>Clinical record review for Resident 42 revealed that the facility completed an enabler bar evaluation dated September 20, 2023, and again on December 17, 2024, which indicated that they passed for potential entrapment. There was no documentation that indicated the facility received consent from Resident 42 or their responsible party to utilize enabler bars or that the facility provided education to Resident 42 and their responsible party regarding the potential risks of utilizing enabler bars until February 17, 2025.</p> <p>Observation of Resident 70's room on February 18, 2025, at 12:15 PM, February 19, 2025, at 1:13 PM, and February 20, 2025, at 8:32 AM revealed that there were bilateral halo-type enabler bars on the bed.</p> <p>Clinical record review for Resident 70 revealed that the facility completed an enabler bar evaluation dated November 14, 2024, and again on December 27, 2024, which indicated they passed for potential entrapment. On January 21, 2025, therapy completed Resident 70's bed enabler assessment and recommended the use of enabler bars for increased bed mobility and independence. There was no documentation that indicated the facility received consent from Resident 70 or their responsible party to utilize enabler bars or that the facility provided education to Resident 70 and their responsible party regarding the potential risks of utilizing enabler bars until February 17, 2025.</p> <p>The surveyor reviewed the above information during an interview with the Nursing Home Director and the Director of Nursing on February 20, 2025, at 2:33 PM.</p> <p>Observation of Resident 33 on February 19, 2025, at 11:40 AM revealed she was in bed with bilateral circular enabler bars on her bed. Concurrent interview with Resident 33 revealed that she uses the right-side enabler bar to help turn but staff have to help her utilize the left one. She indicated the left one was used mostly for her to hold herself over while they complete care on her.</p> <p>Clinical record review for Resident 33 revealed a progress note dated January 21, 2025, at 1:52 PM that indicated a bed enabler assessment was completed on this date, and Resident 33 benefits from the use of bed enablers to increase bed mobility and independence.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Clinical record review revealed that there was no documentation that indicated the facility received consent from Resident 33 to utilize enabler bars or that the facility provided education to Resident 33 regarding the potential risks of utilizing enabler bars until February 20, 2025, after the survey brought it to their attention at a meeting on February 20, 2025, at 3:10 PM.</p> <p>Further clinical record review revealed an enabler bar bed configuration/bedrail/enabler bar form dated March 14, 2024, that indicated zone one (within the bed rail itself), zone two (between the bottom of the rail and the top of the mattress and between the rail supports), zone three (between the outside edge of the mattress and the inside of the side rail), zone four (between the top of the compressed mattress and the bottom of the rail, at the end of the rail), and zone seven (between the end of the mattress and the headboard or footboard of a bed) were evaluated and posed no risk for entrapment. There was no evidence that the facility completed a measurement of zone six (the space between the end of a rail and the side of the headboard or footboard).</p> <p>Employee 1, corporate regional director, confirmed the above noted findings related to Resident 33 during an interview on February 21, 2025, at 10:00 AM.</p> <p>Observation of Resident 109's room on February 18, 2025, at 2:26 PM revealed circular enabler devices bilaterally at the head of her bed. Resident 109's bed was equipped with a headboard and a footboard.</p> <p>Clinical record review for Resident 109 revealed documentation by the facility's therapy staff dated January 21, 2025, at 1:43 PM that assessed that Resident 109 would benefit from the use of bed enablers for increased bed mobility and independence.</p> <p>An Enabler Bar Bed Configuration/Bed Rail/Enabler Bar assessment dated [DATE], revealed that there was no risk for entrapment posed in zones one, two, three, four, and seven as per measurements obtained by maintenance staff. The assessment did not include a review of zone six, which could potentially pose a risk for entrapment between the end of the enabler device and the side of the headboard.</p> <p>Although the facility had installed the enabler devices to Resident 109's bed by January 13, 2025, (which allowed the assessment for entrapment risks), the facility did not obtain informed consent for the devices from Resident 109 until February 19, 2025.</p> <p>Interview with Employee 1 on February 20, 2025, at 12:52 PM confirmed the above findings for Resident 109.</p> <p>28 Pa. Code 211.12 (d)(5) Nursing services</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>20725</p> <p>Based on review of facility documentation, clinical record review, and staff interview, it was determined that the facility failed to ensure that nursing staff possessed the specific competencies and skill sets related to the care and assessment of residents with indwelling urinary catheters, cardiac pacemaker devices, and central venous catheters, for three of three employees reviewed for competencies (Employees 2, 8, and 9; Residents 112 and 114).</p> <p>Findings include:</p> <p>A review of the facility Resident Matrix (CMS-802, form used to identify pertinent care categories for residents who reside in the facility) documentation revealed that the facility had a total of 13 residents with indwelling catheters (insertion of a tube into the bladder to remove urine) within the 107 resident facility census (over 12 percent).</p> <p>The surveyor requested evidence of licensed nursing staff competencies related to indwelling urinary catheters for Employee 2 (registered nurse) and Employee 8 (licensed practical nurse) during an interview with the Nursing Home Administrator, Director of Nursing, and Employee 1 (corporate regional director) on February 19, 2025, at 2:30 PM.</p> <p>Interview with the Nursing Home Administrator on February 20, 2025, at 2:38 PM revealed that the facility had no evidence of competencies related to indwelling urinary catheters for Employee 2 or 8.</p> <p>Clinical record review for Resident 114 revealed a physician's order dated January 30, 2025, to instruct that he wear a Life Vest (external vest worn to continuously monitor a resident's heart rhythm and, if necessary, implement an electrical shock to correct a potentially fatal heart rhythm) at all times except in the shower. A physician's order dated February 1, 2025, instructed staff to ensure that the Life Vest battery was charged and to change the battery when low.</p> <p>Interview with the Nursing Home Administrator on February 20, 2025, at 2:38 PM confirmed that the facility could not provide evidence that Employees 2, 8, or 9 (licensed practical nurse) possessed the necessary knowledge and confirmed competencies related to the Life Vest use.</p> <p>Clinical record review for Resident 114 revealed a physician's order dated January 30, 2025, for staff to assess a PICC (peripherally inserted central catheter, a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near the heart) line site for redness, infiltration (leakage of medications and fluids from the insertion vein into surrounding areas), and/or swelling. A physician's order dated January 31, 2025, instructed staff to change the PICC line dressing weekly using a sterile technique.</p> <p>Clinical record review for Resident 112 revealed a physician's order dated January 24, 2025, that instructed staff not to provide Resident 112 a shower due to an IJ (internal jugular, large central vein in the neck) catheter (central venous catheter (CVC), tubing inserted into a large central vein, most commonly the internal jugular or subclavian).</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Nursing Home Administrator on February 20, 2025, at 2:38 PM, revealed that the facility had no evidence of competencies related to central venous catheter care for Employee 2.</p> <p>28 Pa Code 201.20(a) Staff development</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>20725</p> <p>Based on review of facility documentation and staff interview, it was determined that the facility failed to ensure that nurse aides received an annual performance review and at least 12 hours of in-service education annually for three of three nurse aides reviewed (Employees 10, 11, and 12).</p> <p>Findings Include:</p> <p>Review of available personnel documentation for Employee 10 (nurse aide) revealed that the facility hired her on September 12, 2023.</p> <p>Interview with the Nursing Home Administrator on February 20, 2025, at 2:38 PM revealed that the facility could not provide evidence of an annual performance review (due September 2024) for Employee 10.</p> <p>Review of available personnel documentation for Employee 11 (nurse aide) revealed that the facility hired him on November 15, 2022. A performance evaluation signed by Employee 11 on April 8, 2024, indicated that the evaluation included a period of evaluation from November 15, 2022, to November 15, 2023.</p> <p>Interview with the Nursing Home Administrator on February 21, 2025, at 10:02 AM confirmed that the facility had no evidence to indicate a performance evaluation of Employee 11 for time worked since November 15, 2023.</p> <p>Review of available personnel documentation for Employee 12 (nurse aide) revealed that the facility hired him on May 30, 2023.</p> <p>Interview with the Nursing Home Administrator on February 20, 2025, at 2:38 PM confirmed that the facility could not provide evidence that Employees 10, 11, or 12, received at least 12 hours of mandatory in-service training that addressed any potential areas of weakness as determined by required performance reviews.</p> <p>483.35(d)(7) Nurse Aide Perform Review-12 Hr/yr In-Service</p> <p>Previously cited deficiency 3/15/24</p> <p>28 Pa. Code 201.19(2)(7) Personnel policies and procedures</p> <p>28 Pa. Code 201.20(a)(d) Staff development</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>20725</p> <p>Based on clinical record review and family and staff interview, it was determined that the facility failed to provide behavior health care that was individualized to attain or maintain the highest practical physical, mental, or psychosocial well-being for one of two residents reviewed for mood and behavior concerns (Resident 221).</p> <p>Findings include:</p> <p>Interview with Resident 221's daughter on February 18, 2025, at 10:16 AM revealed that she characterized her mother as detached, and she believed an increase in her mother's antidepressant medication dose might lessen her symptoms of depression. Resident 221's daughter stated that she did not believe that her mother had a good appetite or was attending many activities at the facility.</p> <p>Clinical record review for Resident 221 revealed that the facility admitted her on February 12, 2025.</p> <p>Active physician orders for Resident 221 dated February 12, 2025, included the following psychoactive medications:</p> <p>Mirtazapine (an antidepressant) 15 mg (milligrams) at bedtime for depression</p> <p>Citalopram Hydrobromide (Celexa, an antidepressant) 40 mg one time a day for depression</p> <p>Donepezil Hydrochloride (medication used to improve memory, thinking, and daily functioning for those diagnosed with Alzheimer's dementia (brain disease that affects memory, thinking, personality, and behavior) 10 mg in the morning for dementia</p> <p>A physician's order dated February 13, 2025, added Memantine HCl (Namenda, medication used to treat the symptoms of dementia) 5 mg two times a day for dementia.</p> <p>Interview with Resident 221 on February 19, 2025, at 11:54 AM revealed that she did not leave her room for the bible study activity that morning.</p> <p>Interview with Resident 221 on February 20, 2025, at 10:10 AM revealed that she did not want to leave her room to go to the group activity.</p> <p>Review of Resident 221's meal intake percentages dated since her admission on February 12, 2025, revealed that she consumed 50 percent or less for 14 of the 25 meals reviewed.</p> <p>A plan of care initiated by the facility on February 13, 2025, to address Resident 221's mood problem related to her depression and insomnia (difficulty falling or staying asleep) disease processes included a goal that Resident 221 would have an improved mood state (happier, calmer appearance, no signs or symptoms of depression, anxiety, or sadness) through the next review date.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility cancelled (discontinued) this plan of care for Resident 221 on February 15, 2025.</p> <p>There was no evidence in Resident 221's clinical record that the facility developed another plan of care to address Resident 221's diagnosis or behavioral symptoms of depression.</p> <p>Interview with the Nursing Home Administrator, Director of Nursing, and Employee 1 (corporate regional director) on February 20, 2025, at 2:31 PM confirmed that the facility had no evidence of identifying and tracking behavioral symptoms of Resident 221's diagnoses of depression and dementia. The interview confirmed that the facility did not have an active individualized care plan to address Resident 221's mood problem related to her depression although she received medications to treat that diagnosis.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>18229</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement individualized person-centered care plans to address dementia and cognitive loss displayed by one of three residents reviewed (Resident 91).</p> <p>Findings include:</p> <p>Clinical record review for Resident 91 revealed the facility admitted her on December 9, 2022, with diagnoses including dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life).</p> <p>A review of Resident 91's most recent annual Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated November 2, 2024, indicated that the facility assessed Resident 91 as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed.</p> <p>A review of Resident 91's care plan revealed that there was no indication that the facility had developed and implemented a person-centered care plan to address the resident's dementia and cognitive loss.</p> <p>The findings were reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on February 19, 2025, at 2:30 PM. On February 20, 2025, at 8:03 AM the Nursing Home Administrator confirmed the facility had no further documentation that the facility developed and implemented an individualized person-centered care plan to address Resident 91's dementia.</p> <p>483.40(b)(3) Dementia Treatment and Services</p> <p>Previously cited 3/15/24</p> <p>28 Pa Code 211.12 (d)(1)(3)(5) Nursing services</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395379	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025
NAME OF PROVIDER OR SUPPLIER Wecare at Sycamore Rehabilitation and Nursing Cent		STREET ADDRESS, CITY, STATE, ZIP CODE 1445 Sycamore Road Montoursville, PA 17754	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18229</p> <p>Based on closed clinical record review, review of select policies and procedures, and staff interview, it was determined that the facility failed to ensure the proper disposal and documentation of controlled medications for one of three discharged residents reviewed (Resident 118).</p> <p>Findings include:</p> <p>The facility policy entitled Controlled Substances, last reviewed without changes on [DATE], revealed the facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications. Waste or disposal of controlled medications are done in the presence of the nurse and a witness who also signs the disposition sheet.</p> <p>Closed clinical record review for Resident 118 revealed the facility admitted her on [DATE]. Resident 118 remained in the facility until [DATE], when she was sent to the hospital and later expired.</p> <p>Review of Resident 118's closed record revealed a Controlled Drug Receipt/Record/Disposition Form dated [DATE], indicating the facility received 56 Oxycodone (narcotic pain medication that is considered a controlled substance) 5 milligrams (mg). Further review of the form revealed Employee 2 (registered nurse) documented disposal of Resident 118's Oxycodone (45 tablets). Employee 2 did not date when the Oxycodone was disposed of or have a witness to the disposition of Resident 118's Oxycodone.</p> <p>A Controlled Drug Receipt/Record/Disposition form dated [DATE], indicated the facility received 56 Oxycodone 5 mg. Further review of the form revealed Employee 2 documented disposal of Resident 118's Oxycodone (55 tablets). Employee 2 did not date when the Oxycodone was disposed of or have a witness to the disposition of Resident 118's Oxycodone.</p> <p>A Controlled Drug Receipt/Record/Disposition form dated [DATE], indicated the facility received 27 Lorazepam (an antianxiety medication that is considered a controlled substance) 0.5mg for Resident 118. Further review of the form revealed Employee 2 documented disposal of Resident 118's Lorazepam (one tablet). Employee 2 did not have a witness to the disposition of Resident 118's Lorazepam.</p> <p>A controlled drug record dated [DATE], indicated the facility received 20 Lorazepam 0.5 mg for Resident 118. Further review of the controlled drug record revealed Employee 2 documented disposal of Resident 118's Lorazepam (20 tablets). Employee 2 did not date when the Lorazepam was disposed of or have a witness to the disposition of Resident 118's Lorazepam.</p> <p>A controlled drug record dated [DATE], indicated the facility received 20 Lorazepam 0.5 mg for Resident 118. Further review of the controlled drug record revealed Employee 2 documented disposal of Resident 118's Lorazepam. Employee 2 did not date when the Lorazepam was disposed of or have a witness to the disposition of Resident 118's Lorazepam (20 tablets).</p> <p>Interview with the Nursing Home Administrator, Director of Nursing, and Employee 1 (corporate consultant) on February 20, 2025, at 2:47 PM confirmed these findings.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>483.45 Pharmacy Services</p> <p>Previously cited [DATE]</p> <p>28 Pa. Code 211.9 (j.1)(4)(5) Pharmacy services</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>20725</p> <p>Based on clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that medication labeling was in accordance with currently accepted professional standards and active physician orders for one of eight residents reviewed for medication administration (Resident 221).</p> <p>Findings include:</p> <p>Observation of a medication administration pass on February 19, 2025, at 11:27 AM revealed Employee 4 prepared medications for Resident 221. Employee 4 poured one capsule of Dicyclomine (medication used to decrease muscle spasms in the stomach or bowel to treat symptoms of irritable bowel syndrome). The label on the medication packaging indicated the medication was packaged as 10 milligrams (mg) per each capsule.</p> <p>Clinical record review for Resident 221 revealed that active physician orders since February 12, 2025, instructed staff to administer one capsule of Dicyclomine HCl four times a day. The physician's order did not include the strength of the medication desired (e.g., 10 mg).</p> <p>Continued observation of a medication administration pass for Resident 221 on February 19, 2025, at 12:23 PM revealed Employee 4 prepared and administered 2 gm (grams) of Diclofenac NA one percent gel (Voltaren gel, nonsteroidal anti-inflammatory medicated gel applied to the skin to reduce pain and inflammation) to Resident 221's lower back.</p> <p>Clinical record review for Resident 221 revealed an active physician's order dated February 12, 2025, for staff to administer Voltaren external gel one percent (Diclofenac Sodium (Topical) to affected areas topically four times a day for pain. The physician's order for Resident 221's Voltaren gel did not include a prescribed dose strength (e.g., two grams or four grams) for each administration.</p> <p>Interview with Employee 4 on February 20, 2025, at 10:15 AM confirmed that the physician orders for Resident 221's Voltaren gel and Dicyclomine medication did not include a specific dose that included the strength of the medication. Employee 4 verified that the boxed Voltaren medication permitted a dose that could either be two grams or four grams. The interview confirmed that the labeling on Resident 221's Dicyclomine HCL medication included 10 mg as the strength of the capsule; however, Resident 221's physician order did not include a milligram strength desired. The interview indicated that the nurse who transcribed Resident 221's orders for pharmacy delivery failed to select the strength of the medication desired.</p> <p>The facility failed to ensure that every medication label and every physician order for a medication included the medication name, prescribed dose, and strength, as required.</p> <p>28 Pa. Code 211.9(a)(1)(d)(f)(2)(k) Pharmacy services</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0775</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep complete, dated laboratory records in the resident's record.</p> <p>18229</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure laboratory reports were in residents clinical records for 3 of 22 residents reviewed (Residents 22, 92, and 46).</p> <p>Findings include:</p> <p>Review of Resident 22's clinical record on February 20, 2025, revealed a physician's progress note dated January 13, 2025, at 3:30 PM noting Resident 22's physician requested staff obtain a CBC (complete blood count, a group of blood tests that measure the number and size of the different cells in your blood), BMP (basic metabolic panel, a group of blood tests that assess various aspects of metabolism, electrolyte balance, and kidney function), BNP (B-type natriuretic peptide, test to rule out heart failure), and Troponin (test to diagnose a heart attack, or monitor heart damage), and labs stat (a quick turnaround time, generally an hour or less). There was no evidence in Resident 22's clinical record of the above-mentioned laboratory tests.</p> <p>Review of Resident 92's clinical record on February 20, 2025, revealed a physician's progress note dated January 10, 2025, at 10:30 AM noting Resident 92's physician would repeat the CBC and BMP on January 13, 2025. The physician's progress notes dated January 13, 2025, at 11:28 AM noted lab work was completed on this date. There was no evidence in Resident 92's clinical record of the above-mentioned labs.</p> <p>Review of Resident 46's clinical record on February 20, 2025, revealed a physician's progress note dated February 7, 2025, at 12:27 PM, and February 14, 2025, at 10:35 AM that lab work was completed (CBC, BMP). There was no evidence of this lab work in Resident 46's clinical record.</p> <p>Interview with the Nursing Home Administrator, Director of Nursing, and Employee 1 (corporate consultant) on February 20, 2025, at 3:20 PM confirmed the above-mentioned laboratory reports for Residents 22, 92, and 46 were not available to review. Employee 1 revealed that only two people (the medical director and one other facility physician) have access to view any residents laboratory results in the system. She confirmed the laboratory results were not available in the residents clinical records.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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NAME OF PROVIDER OR SUPPLIER Wecare at Sycamore Rehabilitation and Nursing Cent		STREET ADDRESS, CITY, STATE, ZIP CODE 1445 Sycamore Road Montoursville, PA 17754	

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>18229</p> <p>Based on clinical record review, observation, and staff interview, it was determined that the facility failed to assist a resident to obtain routine dental care for one of one resident reviewed for dental concerns (Resident 46).</p> <p>Findings include:</p> <p>Observation of Resident 46 on February 18, 2025, at 10:41 AM and February 19, 2025, at 11:30 AM revealed he was in bed. Attempted to interview Resident 46 several times and he refused to answer questions, stating he was too tired and would not open his eyes. Observation of Resident 46's teeth at these times revealed what appeared to be a buildup of plaque on his teeth.</p> <p>Clinical record review revealed the facility admitted Resident 46 on February 22, 2018, with payment sources that included the state Medicaid benefit.</p> <p>Review of Resident 46's clinical record revealed he saw a dentist on April 12, 2023. A review of the progress note revealed Resident 46 had a heavy buildup of plaque, and he would be due for his next visit for prophylactic dental cleaning in six months.</p> <p>Further review of Resident 46's clinical record revealed he did not receive dental services again until July 15, 2024. A review of the progress note revealed Resident 46 had heavy food debris, heavy plaque on his teeth, and he would be due for his next visit for prophylactic dental cleaning in six months.</p> <p>The facility failed to provide evidence that Resident 46 received routine prophylactic dental cleanings as covered under the State plan.</p> <p>Interview with the Nursing Home Administrator and Director of Nursing on February 20, 2025, at 2:58 PM confirmed these findings.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>18229</p> <p>Based on observation and staff interview, it was determined that the facility failed to store food in accordance with professional standards for food service safety in the facility's main kitchen.</p> <p>Findings include:</p> <p>Initial tour of the facility's main kitchen on February 18, 2025, at 9:03 AM with Employee 5 (director of dining services) revealed the following:</p> <p>The refrigerator had a tray of ground beef thawing above a shelf with eggs.</p> <p>The refrigerator had three opened containers of beef base, with a date of September 7, 2024. There was a fourth container of beef base with no date.</p> <p>The refrigerator contained a large container of lemon juice with a use by date of January 18, 2025.</p> <p>The refrigerator contained a large container of salsa with a use by date of January 25, 2025.</p> <p>The refrigerator contained a large container of mustard with a use by date of April 8, 2024.</p> <p>The refrigerator contained a large container of BBQ sauce with a use by date of February 7, 2025.</p> <p>Interview with Employee 5 on February 18, 2025, at 9:31 AM revealed that dietary staff are expected to mark food items with a received by, opened, and use by dates. Employee 5 confirmed these findings and threw out all the above-mentioned food items.</p> <p>The Nursing Home Administrator and Director of Nursing were made aware of the findings during a meeting on February 19, 2025, at 2:30 PM.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>20725</p> <p>Based on a review of Quality Assessment and Assurance (QAA) meeting attendance and staff interview it was determined that the facility failed to ensure the committee consisted of the minimum members (medical director and Director of Nursing) at least quarterly.</p> <p>Findings include:</p> <p>Review of QAA meeting attendance records dated April 2024, to the final date of the onsite survey, February 21, 2025, revealed that the facility's most recent QAA committee meeting occurred on December 23, 2024.</p> <p>Attendance records indicated that the facility medical director did not attend a QAA meeting in the almost seven months since July 25, 2024, and the Director of Nursing did not attend a QAA meeting in the almost four months since October 24, 2024.</p> <p>Interview with the Nursing Home Administrator on February 21, 2025, at 9:26 AM confirmed that the facility failed to ensure at least quarterly QAA meeting attendance by the Director of Nursing and the facility's medical director (or designee).</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(3)(e)(3) Management</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>20725</p> <p>Based on observation and resident and staff interview, it was determined that the facility failed to ensure an environment free from the potential spread of infection on two of five nursing units (Grampian: Residents 109, 112, 113, and 223; and Sycamore: Resident 22).</p> <p>Findings include:</p> <p>Review of the Centers for Medicare and Medicaid Services (CMS) memo entitled, Enhanced Barrier Precautions in Nursing Homes, dated March 20, 2024, revealed that nursing care facilities are to use enhanced barrier precautions (EBP, gown and glove use) for residents with chronic wounds or indwelling medical devices (i.e., indwelling urinary catheters) during high-contact resident care activities regardless of their multidrug-resistant organism status. High-contact activity would include things like dressing, transferring, changing linens, providing hygiene, changing briefs, wound care, or device care.</p> <p>Observation of Resident 223 on February 19, 2025, at 10:41 AM revealed tubing from an indwelling urinary catheter (flexible tubing inserted into the bladder to drain urine). Observation of Resident 223's room revealed no evidence of the implementation of EBP.</p> <p>Interview with Employee 4 (licensed practical nurse) on February 19, 2025, at 10:45 AM confirmed that although Resident 223 had an indwelling urinary catheter, the facility did not implement EBP for her.</p> <p>Interview with Resident 112 on February 18, 2025, at 1:17 PM confirmed that he received hemodialysis (treatment for kidney failure; a machine filters extra fluid and waste products from the blood) services three times a week. Resident 112 stated that he had an intravenous access site (central venous catheter (CVC), tubing inserted into a large central vein, most commonly the internal jugular or subclavian, for long-term treatment access) in his right upper chest that was used for hemodialysis. Resident 112 also stated that he had open sores on his legs that staff treat with wound care.</p> <p>Observations in and around Resident 112's room and doorway on February 18, 2025, at 1:34 PM revealed no EBP in place.</p> <p>Interview with Employee 4 on February 18, 2025, at 1:54 PM confirmed that the facility should have implemented EBP for Resident 112 due to his dialysis access site and leg wounds; however, there was no evidence of any EBP in place.</p> <p>Observation of a medication administration pass on February 19, 2025, at 11:37 AM revealed Employee 4 washed her hands in Resident 109's sink. After cleansing and rinsing her hands, Employee 4 used her clean hand to turn the faucet off before obtaining a paper towel to dry her hands.</p> <p>Continued observation of a medication administration pass on February 19, 2025, at 11:43 AM revealed Employee 4 administered medications to Resident 113 then washed her hands in his bathroom sink. Employee 4 used her clean hand to turn off the faucet before obtaining a paper towel to dry her hands.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with Employee 4 on February 19, 2025, at 12:29 PM confirmed that she did not use a paper towel to turn off the water faucet to maintain the cleanliness of her hands. Employee 4 confirmed that it was the facility's policy to not touch the faucet after handwashing.</p> <p>The surveyor reviewed the Grampian nursing unit infection control concerns during an interview with the Nursing Home Administrator on February 20, 2025, at 11:15 AM.</p> <p>Clinical record review revealed the facility admitted Resident 22 on September 25, 2023. Observation of Resident 22 on February 18, 2025, at 10:23 AM revealed there was a sign on the Resident 22's door indicating she was on contact precautions. Interview with Employee 13 (nurse aide) at this time revealed that she was unsure why Resident 22 was on contact precautions.</p> <p>Review of Resident 22's clinical record revealed there was a physician's order for contact precautions related to ESBL (extended-spectrum beta-lactamase, an enzyme that makes bacteria resistant to many antibiotics) in Resident 22's urine, initiated November 20, 2024.</p> <p>Interview with Employee 14 (infection preventionist) on February 19, 2025, at 8:08 AM revealed that Resident 22 has ESBL in her urine and has a catheter, but her urine is not contained due to her catheter leaking at times.</p> <p>Review of Resident 22's care plan on February 19, 2025, revealed there was no plan of care addressing Resident 22's contact precautions. Further review of Resident 22's clinical record revealed the Kardex (summary of resident information used as a reference guide for staff caring for the resident) listed no infection control instructions for Resident 22.</p> <p>The surveyor reviewed the Sycamore nursing unit infection control concerns with Resident 22 during a meeting with the Nursing Home Administrator and Director of Nursing on February 20, 2025, at 2:30 PM.</p> <p>483.80(a)(1)(2)(4)(e)(f) Infection Prevention and Control</p> <p>Previously cited deficiency 3/15/24</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36798</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure that a residents medical record included documentation that the residents representative was provided education regarding the risks and benefits of the influenza immunization for one of five residents reviewed for immunization concerns (Resident 92).</p> <p>Findings include:</p> <p>Clinical record review for Resident 92 revealed a quarterly MDS (Minimum Data Assessment, an assessment tool completed at specific intervals to determine care needs) assessment dated [DATE], indicated the resident had a BIMS (Brief Interval for Mental Status) score of eight, indicating he had moderate cognitive impairment.</p> <p>Review of Resident 92's immunization documentation revealed that Resident 92's family refused for him to have an influenza (flu) vaccination on August 14, 2024. The documentation also indicated that the facility did not provide the family with education related to the risk and benefits of the influenza vaccination.</p> <p>The facility could not provide evidence that Resident 92's responsible party was given education regarding the risks and benefits of the influenza vaccination (given Resident 92's incapacity to be his own responsible party for medical decisions) for them to make an informed decision regarding the vaccination administration to Resident 92.</p> <p>Interview with Employee 1, corporate regional consultant, on February 21, 2025, at 11:24 AM confirmed the above noted findings that there was no evidence Resident 92's responsible party was educated on the risk and benefits of the influenza vaccine for them to make an informed decision regarding vaccine administration.</p> <p>The Nursing Home Administrator and Director of Nursing were made aware of the above noted concerns related to Resident 92 on February 21, 2025, 12:32 PM.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 211.5(f) Medical records</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		